DEPARTMENT OF HEALTH AND HOSPITALS
Aging and Adult Services

QUARTERLY
SERVICE DELIVERY MONITORING AND RISK ASSESSMENT
OAAS Support Coordination Documentation

Case No: _____   Service Log No. _____

Participant: _____   Activity: _____

SC ID: _____   _____

Date: _____   _____

 Begin Time: ___: __ _ (hh: mm)   Service Participants: _____

End Time: ___: ___ _ (hh: mm)   _____

 Place of Service: ____   _____

 Type of Contact: ____   _____

Travel Log   Begin Mileage:_____   End Mileage: _____

I. GENERAL QUESTIONS:

- **Answer all questions below <u>as applicable</u>.**
- **For all "NO" answers, please describe in the narrative section how it was addressed.**

Review in home or ADHC <u>as applicable</u>:	YES	NO	N/A
1. Plan of Care is in- home/on- site (current & approved)?			
2. OAAS Participant's Rights & Responsibilities Form (OAAS-RF-10- 005) in-home?			
3. Is provider service documentation in- home/on- site according to provider requirements?			
4. Is the Support Coordination Agency's toll free number available in- home?			
5. Is the PAS or LT-PCS provider's toll free number available in- home (when required)?			
6. Is the OAAS Waiver Help- Line toll free number available in- home?			
7. If the provider documentation indicates a critical incident occurred, was a CIR completed?			
8. Did the participant attend the ADHC at least 36 days in the last quarter?			
9. Is ADHC transportation being provided as specified in the POC?			
Ask the participant <u>as applicable</u>:			
11. Does the worker arrive/leave according to the service log/time sheets?			
12. Are all assistive devices identified in the POC working properly?			
If the POC was renewed since the last quarterly contact, enter: Date(s) sent to the Provider: _____ and Participant: _____			

I. Narrative Section:
(Name/relation of person giving information)

II. **QUARTERLY RISK ASSESSMENT** (Questions 4-6 apply to PAS & LT-PCS only)	YES	NO	N/A
1. Is the Emergency Plan and Agreement Form up-to-date? Name of the person who verified :_____.			
2. If the Emergency Plan and Agreement was executed was it effective?			
3. If the Emergency Plan and Agreement Form is not up-to-date or not effective has it been revised? Summarize, if applicable. Date revised:_____			
4. Is the Individualized Back-Up Staffing and Agreement Form up-to-date? Name of the person who verified :_____.			
5. If the Individualized Back-Up Staffing and Agreement was executed was it effective?			
6. If the Individualized Back-Up Staffing and Agreement Form was not up-to-date or not effective has it been revised? (Summarize revisions)Date revised:_____			
7. Risk factors for the quarter were reassessed and **a summary of how present risks were mitigated during this quarter including all risk factors identified**.			

RISK ASSESSMENT NARRATIVE:

(Summarize all risks identified through the CAPS, *Risk Assessment & Referral Screening Tool* and the *Monthly SCD)*

III. MONITORING OF ONGOING SERVICES:

During each quarterly visit, the SC evaluates delivery of ongoing services for the previous quarter. This section applies only to PAS, ADHC and LT-PCS as applicable.

Instructions:	
1. Review service delivery documentation for the previous quarter. 2. Discuss last quarter's service delivery with the participant or authorized representative. 3. Determine whether all ongoing services in the POC were delivered in the amount, frequency, and duration specified in the service plan. <u>If so select code 01 and proceed to IV.</u> 4. For any ongoing service **NOT** delivered according to the POC for the quarter, <u>check applicable code below and enter supporting details in the narrative section.</u> 5. Enter Codes in CMIS. (Codes must be entered for payment).	*__At least one__ service monitoring code must be checked (√) for each applicable service:*

III.A. Service Monitoring Codes: • **Check all that apply**	*PAS or LT-PCS*	*ADHC*
01 All ongoing services were delivered in the amount frequency and duration specified in the POC.		
02 Participant was temporarily admitted to an institutional care facility.		
03 Scheduled PAS services were <u>voluntarily</u> declined because family or other caregivers were able to temporarily offer additional unpaid supports. (Excluding Back-up Staffing plan)		
04 ADHC Unable to attend due to unscheduled closures or weather.		
05 PAS hours not received due to unplanned worker absence and **family or other natural support assumed responsibility as specified in the back-up staffing plan.**		
06 PAS hours not received due to participant refusing relief worker.		
07* PAS hours not received due to unplanned worker absence and **PAS provider did not assume coverage as specified in the back-up staffing plan.**		
08* Participating in Self-Direction Program and PAS hours not received due to unplanned worker absence and **coverage was not assumed according to backup staffing plan.**		

III.B. Remediation Activity Code: **Check any that apply** ***MUST ENTER AT LEAST ONE REMEDIATION CODE WHEN 07 or 08 HAS BEEN SELECTED**	*PAS or LT-PCS*	*ADHC*
09R Remediation in Progress (Explain in narrative)		
10R Assisted participant in locating other providers who could best meet their needs		
11R Change to Back up Staffing Plan		
12R POC Revision for Provider Change		
13R New worker in place by PAS provider		

IV. MONITORING ALL TYPES OF SERVICES DELIVERED

- The SC evaluates whether all types of services in the POC were received **during the final quarter of the POC year or month of discharge,** as applicable.

Instructions:	*At least one service monitoring code must be checked (√) for each applicable service:*
1. Determine whether **all types** of services in the POC were delivered within the plan year. If yes, enter the appropriate CMIS code FOR EVERY SERVICE. 2. For any service types specified in the POC which were **NOT** delivered during the POC year, check applicable code below and enter supporting details in the narrative section. 3. If an undelivered service is due to any reason requiring remediation code as 18, and document the remediation activities which have occurred. 4. Enter Codes in CMIS. (Codes must be entered for payment)	

IV.A Service Monitoring Codes: Check all that apply for each service in the POC	ADHC	CTSS	ADMS	EAA	HDM	NMT	Nurs-ing	PAS	SMT	TS
14 All types of services in the POC were delivered within the plan year.										
15 Health decline after person admitted to waiver resulting in discharge prior to service delivery.										
16 Participant changed his/her mind about service and POC was changed to remove service.										
17 SC contacted all providers in the Provider Locater Tool and no enrolled service provider could be found to meet participant's needs.										
18* Reason Requiring Remediation: Any reason other than 14-17										

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IVB. Remediation Activity Codes: Must enter a remediation code(s) below whenever code 18 has been selected **Check all that apply:**	ADHC	CTSS	ADMS	EAA	HDM	NMT	Nurs-ing	PAS	SMT	TS	
19R *Remediation in progress* *(Explain in narrative)*											
20R *POC amended to accurately describe current situation and service needs*											
21R *Documentation that services were appropriately discontinued*											
22R *The participant began receiving the type of service specified in the plan*											
23R *No provider within a reasonable transport radius (Shows up only in the drop down for center-based services)*											

SERVICE DELIVERY MONITORING NARRATIVE
(Refer to Sections III. & IV. instructions above)

ADDITIONAL NARRATIVE FOR SECTIONS I.-IV.

Use this section when extra space is needed for narrative: Indicate applicable section number(s)

SC Signature_____ Date: _____